

Centers for Medicare & Medicaid Services, HHS

§ 457.600

(c) *Institutional emergency services.* For Federal FY 2009, any copayment that the State imposes on emergency services provided by an institution may not exceed \$5.70. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(d) *Non-emergency use of the emergency room.* For Federal FY 2009, for targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of \$11.35 for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10. Thereafter, any charge may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(e) *Standard copayment amount.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in paragraphs (a), (b), and (c) of this section to the State's average or typical payment for that service.

[66 FR 2681, Jan. 11, 2001, as amended at 73 FR 71854, Nov. 25, 2008; 75 FR 30265, May 28, 2010]

§ 457.560 Cumulative cost-sharing maximum.

(a) A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State.

(b) The State must inform the enrollee's family in writing and orally if appropriate of their individual cumulative cost-sharing maximum amount

at the time of enrollment and reenrollment.

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program in accordance with § 457.1130(a)(3).

Subpart F—Payments to States

§ 457.600 Purpose and basis of this subpart.

This subpart interprets and implements—

(a) Section 2104 of the Act which specifies the total allotment amount available for allotment to each State for child health assistance for fiscal years 1998 through 2015, the formula for determining each State allotment for a fiscal year, including the Commonwealth and Territories, and the amounts of payments for expenditures that are applied to reduce the State allotments.

(b) Section 2105 of the Act which specifies the provisions for making payment to States, the limitations and conditions on such payments, and the calculation of the enhanced Federal medical assistance percentage.

[66 FR 2670, Jan. 11, 2001, as amended at 76 FR 9246, Feb. 17, 2011]